DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OTC 9/30/10

PRINTED: 08/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445314	A. BUILDING _____ B. WING _____	C 08/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MORRISTOWN	501 WEST ECONOMY ROAD MORRISTOWN, TN 37814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During investigation of C/O # 25825, #25258, #25956 and #26069, conducted August 2-27, 2010, at Life Care Center of Morristown, no deficiencies were cited for C/O #25825, #25258 and #25956 under 42 CFR PART 483, Requirements for Long-Term Care Facilities. A deficiency was cited at F221 for C/O #26069.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure residents were assessed for the use of a restraint before a gait belt was used as a restraint convenience device to manage the behaviors for two residents (#9, #10) of ten residents revlewed. The findings included: Resident #9 was admitted to the facility on July 15, 2009, with diagnoses including Dementia and Hypertension. Medical record review of the Minimum Data Set (MDS) dated June 27, 2010, revealed the resident had short and long-term memory problems and severely impaired decision-making skills; was easily distracted and had periods of altered perception or awareness of surroundings; had repetitive, anxious complaints and wandering behavior; required limited assistance with bed mobility and transfers; and	F 221	*What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* **Identified residents involved, performed head to toe assessements of all residents on Sprecial Care Unit for adverse effect (6-16-10), had Social Services follow-up with individuals affected (6-16, 17-10). Immediate dismissal of associate involved in offense. (6-17-10) Education was given to all associates regarding Residents Rights and appropriate reporting of any and all violations to administration. (Completed 6-18-10)** Education conducted by Exec. Director and DON.	6-18-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kellie Coats Henley — TITLE: Executive Director — (X6) DATE: 08/30/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 had a history of falls in the prior one-hundred-eighty days. Medical record review of a physician's recapitulation order dated June 1-30, 2010, revealed, " ...Alarming clip belt to w/c (wheelchair). Check every 30 min (minutes). Release every 2 hours ..." Medical record review of the restraint assessments dated December 28, 2009, March 23, 2010, and June 21, 2010, revealed an alarming clip belt was in place. Medical record review of nurses' notes dated April 21, 2010, through June 8, 2010, revealed the resident was able to move the wheelchair short distances with the feet and attempted to stand from the wheelchair. Review of a termination form dated June 17, 2010, revealed Licensed Practical Nurse (LPN) #1, "Asked a CNA (Certified Nursing Assistant) to physically restrain a resident in w/c using a gait belt to affix to handrail in hallway. Asked on several occasions for gait belt of CNA to restrict movement on unit." Continued review of the termination form revealed LPN #1 was terminated for "Improper restriction/restraint of resident." Review of documentation by LPN #1 on the termination form dated June 17, 2010, revealed, "I was thinking of keeping resident from leaning forward and tilting chair over forward or backward and hitting their head on floor and causing hematoma." Medical record review of a Social Worker note dated June 17, 2010, revealed, "Follow up with resident concerning improper use of restraint.	F 221	*How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* **All residents have the potential to be affected by this practice. All residents who utilize restraints are assessed monthly and prn by interdisciplinary team (nursing, MDS coordinators, therapy) for most appropriate use of restraint. Education is provided upon hire, quarterly, and prn to all associates regarding: Abuse, Resident Rights and timely reporting of any indiscretions of these. Immediate physical assessment of resident condition, assurance of safety and disciplinary action (termination) to associates who do not follow policy/procedure for restraints.**	6-18-10

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F 221	Continued From page 2 Resident demonstrates no ill effects from improper application of restraint. Behavior consistent (with) baseline ..." Interview on August 3, 2010, at 2:00 p.m., in the conference room, with the Administrator and the Director of Nursing (DON) confirmed resident #9 had a clip alarm in place when up in the wheelchair, and the resident's wheelchair had been "tied to the handrail" (determined later in the investigation to have occurred on June 15, 2010, on the 11:00 p.m., to 7:00 a.m., shift). Continued interview with the Administrator and the DON confirmed the resident had been placed in a double restraint. Observation on August 4, 2010, revealed the resident was not on the secured unit. Interview on August 4, 2010, at 11:40 a.m., with the day shift charge nurse on the secured unit revealed the resident was in the hospital. Telephone interview on August 4, 2010, at 3:35 p.m., with CNA #1 (on duty on the 11:00 p.m., to 7:00 a.m., shift) on the secured unit on June 15, 2010, confirmed LPN #1 instructed CNA #1, "Use the gait belt and tie (resident #9) to the handrail." Continued interview with CNA #1 confirmed a clip belt alarm was in place on resident #9 on June 15, 2010, when CNA #1 secured the wheelchair to the handrail using a gait belt. Telephone interview on August 5, 2010, at 10:10 a.m., with LPN #1 revealed on June 15, 2010, on the 11:00 p.m., to 7:00 a.m., shift, resident #9, "Kept leaning forward ...saw spots in the floor ...tried to pick spots off floor ...scared to death (resident) was going to tilt w/c forward and hit ...head." Continued interview with LPN #1	F 221	*What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?* **Education to all associates about proper use of restraints and timely reporting if the appropriate use of restraints is not being followed, focus on resident rights and dignity.** Education conducted by Exec. Director and DON.	6-18-10

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F 221	Continued From page 3 confirmed a clip alarm, which the resident was not able to remove, was in place at the same time the wheelchair was secured to the handrail using a gait belt. Continued interview with LPN #1 confirmed the resident had been in a double restraint "a few times" but not every night. Resident #10 was admitted to the facility on January 28, 2010, with diagnoses including Anemia, Depression, Alzheimer's Disease, Psychosis and Chronic Ischemic Heart Disease. Medical record review of the MDS dated July 18, 2010, revealed the resident had short and long-term memory problems and moderately impaired decision-making skills; was easily distracted and had repetitive physical movements; had wandering and socially inappropriate behaviors and resisted care; required extensive assistance with bed mobility and transfers; and had no history of falls in the prior one-hundred-eighty days. Medical record review of a physician's recapitulation order dated June 1-30, 2010, revealed, " ...high back w/c with anti-tippers ...pelvic posey ...check posey every 30 minutes & (and) release every 2 hours ..." Medical record review of the restraint assessments dated February 1, 2010, and April 30, 2010, revealed a pelvic posey was in place when the resident was in the wheelchair. Medical record review of a nurse's note dated June 14, 2010, revealed the resident was able to "self-propel" in the wheelchair. Review of a termination form dated June 17, 2010, revealed Licensed Practical Nurse (LPN)	F 221	*How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e.: what quality assurance program will be put into place?* **Performance Improvement Plan initiated to address proper use of restraints in keeping with residents rights and dignity. Will be reviewed in PI meeting by committee comprised of Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, Nursing Administration, Social Services, Dietary, Laundry, Housekeeping, Staff Development Coordinator. Started 6-18-10 and ongoing till 9-18-10.**	9-18-10

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F 221	Continued From page 4 #1, "Asked a CNA (Certified Nursing Assistant) to physically restrain a resident in w/c using a gait belt to affix to handrail in hallway. Asked on several occasions for gait belt of CNA to restrict movement on unit." Continued review of the termination form revealed LPN #1 was terminated for "Improper restriction/restraint of resident." Review of documentation by LPN #1 on the termination form dated June 17, 2010, revealed, "I was thinking of keeping resident from leaning forward and tilting chair over forward or backward and hitting their head on floor and causing hematoma." Medical record review of a Social Worker note dated June 17, 2010, revealed, "Follow up visit (with) resident concerning improper use of restraint. Resident demonstrates no adverse effects from improper application of restraint ..." Observation on August 4, 2010, at 11:40 a.m., revealed the resident was in a wheelchair with anti-tippers in place on the back of the wheelchair, and a pelvic posey restraint was in place. Interview on August 3, 2010, at 2:00 p.m., in the conference room, with the Administrator and the Director of Nursing (DON) confirmed resident #10 had a pelvic posey restraint in place when up in the wheelchair, and the resident's wheelchair had been "tied to the handrail." Continued interview with the Administrator and the DON confirmed the resident had been placed in a double restraint. Telephone interview on August 4, 2010, at 3:35 p.m., with CNA #1 (11:00 p.m., to 7:00 a.m., shift on secured unit) confirmed LPN #1 had instructed CNA #1 to, "Use the gait belt and tie (resident	F 221		

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F 221	Continued From page 5 #10) to the handrail ...two or three times." Continued interview with CNA #1 confirmed the resident had a pelvic posey restraint applied at the same time the wheelchair was secured to the handrail. Telephone interview on August 5, 2010, at 10:10 a.m., with LPN #1 confirmed a pelvic posey restraint was in place at the same time resident #10"'s wheelchair had been secured to the handrail "five to eight times" using a gait belt. C/O #26069	F 221		